

Operating Model and Insurance Rules Advisory Committee Meeting Minutes

**October 25, 2011
10:00 a.m. – 12:30 p.m.
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215**

The materials presented in the meeting are listed on the Maryland Health Benefit Exchange webpage: <http://dhmh.maryland.gov/healthreform/exchange/AdvComm/mtg-model-ins.html>

Members Present

Uma Ahluwalia (Co-Chair)	Jonathan Anders (Co-Chair)
Virginia (Penny) Anderson	Paul Berman
Vincent DeMarco	Kendall Hunter
Cristinia Meneses	John Miller*
Paul Nicholson	Mark Sucoloski
Tequila Terry	Sally Tyler
Susan Wood	Kevin Yang
Charles Yarborough	

Others Present

Therese Goldsmith (Board Liaison)
Becca Pearce (Executive Director of the Maryland Health Benefit Exchange)

Members Absent

Salliann Alborn
Laura Howell
Aaron Kaufman

Welcome and Introductions

The Co-Chairs welcomed everyone and asked the Committee to approve minutes from the last meeting. After discussing and agreeing to revisions, the minutes were approved and staff presented an update on each of the other advisory committees' activities. Meeting materials and presentations of the other committees, which may be of interest to the work of the Operating Model and Insurance Rules Committee, are publicly available on the Exchange website.¹ Several comments stressed that topic areas overlap between the Finance and Sustainability Advisory Committee and this one. However, it was reaffirmed that each committee has specific questions to address.

¹ <http://dhmh.maryland.gov/healthreform/exchange/advisorycommittees.html>

Presentation on Market Principles, Contracting Options for Qualified Health Plan (QHP) Certification in Maryland, and Regional Contracting Options

Wakely Consulting Group began their presentation on market information by highlighting key takeaway points, including the fact that Maryland has a concentrated market in regards to carriers, that there is little overlap between Medicaid and commercial insurance markets, and that the unique state regulatory environment presents its own set of opportunities and challenges for the Exchange. It was noted that only two carriers—United Healthcare and Coventry—are in both the Medicaid and commercial health insurance markets. With some context for the existing Maryland marketplace, Wakely hoped to foster discussion of the questions that have been posed to the Committee—specifically, how selective contracting could be structured and used as a tool of the Exchange and how to consider multistate or regional contracting.

In past meetings, Wakely framed the starting point for the discussion with the role of the Exchange as acting either as a facilitator or a selective contractor. However, it was noted that the role also can be thought of as a continuum with varying levels of flexibility. A key decision point that was raised to the Committee was whether the Exchange should have the flexibility to include criteria not specified in the Affordable Care Act (ACA) for certifying QHPs. The committee largely coalesced around the opinion that the Exchange should be given that level of flexibility and otherwise left it up to the Board and the Executive Director to make the best decisions for Maryland.

Yet, the follow-up question of what level of selectivity or standardization the Exchange should adopt did not yield as much consensus. Four models of certification options were presented: 1) any qualified carrier with no additional criteria above the ACA minimum, 2) any qualified carrier using additional criteria above the ACA minimum, 3) competitive bidding/selective contracting, and 4) one on one negotiation with qualified plans. It was noted that outside of Option 1, regardless of the model chosen, the Exchange can calibrate the appropriate level of selectivity and standardization. Some Committee members thought that the Exchange should consider Options 2 and 4 as those would both allow Maryland to structure QHPs in such a way that they exceed minimum ACA requirements but still give flexibility to the Exchange in determining the degree to which criteria should exceed federal minimums. Others suggested that Option 1 be the starting point, with the desire being to initially cast a wide net to encourage carriers into participate in the Exchange before raising the bar for QHP certification. This approach is thought to generate affordable health plans through the competition generated by allowing more plans to be certified as QHPs. Some feared that applying a more selective approach to contracting would cause carriers to not participate both inside and outside the Exchange which, in turn, could have negative consequences such as adverse selection. One potential solution could be to require a carrier to participate inside the Exchange if it wishes to participate outside the Exchange. Additionally, there was a concern with Option 4 and whether having individual negotiations could meet the statutory intent of the Exchange to provide a transparent marketplace.

There was a great deal of discussion around what the goals of the Exchange should be and their impact on QHP certification criteria. It was stated that the purposes of the Exchange are listed in the enabling legislation as: 1) reduce the number of uninsured in the state; 2) facilitate the purchase and sale of qualified health plans in the individual market in the state by providing a transparent marketplace; 3) help qualified employers in the state facilitate the enrollment of their

employees into qualified health plans in the small group market and access small business tax credits; 4) assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and 5) supplement the individual and small group insurance markets outside of the Exchange.

Regional and multistate contracting was the next item up for discussion. Wakely presented three ways to think about the topic: 1) baseline, 2) facilitate regional coverage, and 3) collaborate with other state Exchanges. Committee members agreed that Option 2 was effectively what is in place currently, and that it would be most efficient to continue with that option because it would allow multistate coverage for businesses with non-Maryland employees. Most committee members believed that Option 3 would be too difficult to coordinate with other states that are going through similar processes establishing their own Exchanges.

Public Comments

A CareFirst representative reiterated that they have a strong concern about applying selective contracting methods that could hamper participation in the Exchange. The League of Life and Health Insurers of Maryland's Executive Director wanted to support a minimum floor of standards for QHP certification that could eventually be ramped up. They expressed the opinion that the Exchange should gain experience in the newly created marketplace before applying stricter participation guidelines. Finally, the Maryland Health Care Commission suggested that their website for health plan report cards and their Virtual Compare Tool may be worthwhile resources for the Committee to view.

Next Steps

Commissioner Goldsmith relayed a reminder from the Exchange Board that Advisory Committee Members' commitment extends through June 30, 2012. However, the frequency of the Committee meetings should be reduced following the meeting on November 7th. The next meeting is November 2, 2011, from 10:00 a.m. to 12:30 p.m. at the UMBC Tech Center in Baltimore.